

NURSING MANAGEMENT

An analysis of delegation styles among newly qualified nurses

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Conflict of interest

None declared

Abstract

Aim The aim of this research was to explore how newly qualified nurses learn to organise, delegate and supervise care in hospital wards when working with and supervising healthcare assistants. It was part of a wider UK research project to explore how newly qualified nurses recontextualise the knowledge they have gained during their pre-registration nurse education programmes for use in clinical practice.

Method Ethnographic case studies were conducted in three hospital sites in England. Data collection methods included participant observations and semi-structured interviews with newly qualified nurses, healthcare assistants and ward managers. A thematic analysis was used to examine the data collected.

Findings Five styles of how newly qualified nurses delegated care to healthcare assistants were identified: the do-it-all nurse, who completes most of the work themselves; the justifier, who over-explains the reasons for decisions and is sometimes defensive; the buddy, who wants to be everybody's friend and avoids assuming authority; the role model, who hopes that others will copy their best practice but has no way of ensuring how; and the inspector, who is acutely aware of their accountability and constantly checks the work of others.

Conclusion Newly qualified nurses require educational and organisational support to develop safe and effective delegation skills, because suboptimal or no delegation can have negative effects on patient safety and care.

Keywords

delegation, delegation skills, delegation styles, healthcare assistants, management, newly qualified nurses, patient safety, preceptorship, staff supervision

NURSES ARE INCREASINGLY delegating aspects of patient care to healthcare assistants, whose contributions are essential to patient care, but who often lack formal healthcare qualifications. The reasons for this are multifaceted and associated with cost, lack of resources and the expansion of the healthcare assistant role (Sikma and Young 2001, Gillen and Graffin 2010, Weydt 2010). The literature on delegation in the UK has focused on the delegation of specific tasks such as medication (Dickens et al 2008), skills mix and role expectations (Gillen and Graffin 2010), and perceptions of and

satisfaction with healthcare assistants among staff and patients (Keeney et al 2005). How nurses learn to delegate care has not previously been covered in the literature.

The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (Nursing and Midwifery Council (NMC) 2015) emphasises the importance of delegation, stating that nurses and midwives are expected to be 'accountable for [their] decisions to delegate tasks and duties to other people' (NMC 2015). The Code (NMC 2015) states that nurses should only delegate tasks that are within the other

person's scope of competence, and that everyone who has been delegated tasks should be adequately supervised. Nurses and midwives are also accountable for ensuring the outcomes of the delegated tasks meet the required standard.

Delegation has been defined as 'the transfer of responsibility for the performance of an activity from one individual to another while retaining accountability for the outcome' (American Nurses Association 1992). It is linked to responsibility, accountability and authority (Weydt 2010). Inappropriate delegation might lead to suboptimal patient outcomes and have negative effects on patient safety (Standing and Anthony 2008). Quality of care and delegation are closely linked and is an area where errors can occur (Anthony and Vidal 2010). While delegation was not raised as a specific issue of concern in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis 2013), the report found that suboptimal nursing leadership and staffing policies had led to declining professionalism and a general tolerance of inadequate care standards.

The authors suggest that not enough is known about how nurses learn to delegate and supervise the work of healthcare assistants. Strengthening nurse delegation and supervision skills has the potential to improve patient safety and the coordination of bedside care (Weydt 2010). Effective nurse delegation requires nurses to act as advocates for patients and to demonstrate assertiveness, leadership and change management skills (Walczak and Absolon 2001). Assertiveness is an essential skill that helps nurses to develop effective relationships with all members of the multidisciplinary team (Lin et al 2004).

Aim

The aim of this research was to explore how newly qualified nurses learn to organise, delegate and supervise care in hospital wards when working with and supervising healthcare assistants. It was part of a wider UK research project

to explore how newly qualified nurses recontextualise the knowledge they have gained during their pre-registration nurse education programmes for use in clinical practice.

Method

The study involved an ethnographic case study design, and data were obtained from three hospital trusts in England between 2012 and 2014. According to Yin (2014), a case study is an empirical inquiry that enables collection of data in its real-life context, often drawing on a range of data collection methods.

The study design drew on an ethnographic methodology, which involves becoming fully immersed in the environment being studied, and generally includes participant observations (Hammersley and Atkinson 2007). Ethnographic research, although time-consuming and expensive, is increasingly used in healthcare research, which often requires in-depth exploration of contextual details and the interpretation of shared meanings in the setting being studied (Hammersley and Atkinson 2007). Ethnography offers a framework to synthesise findings from different data collection methods as well as providing a 'holistic way of exploring the relationship between the different kinds of evidence that underpin clinical practice' (Savage 2006).

Exploring how newly qualified nurses learn to supervise and delegate care is complex and influenced by micro factors, such as the patient or ward; meso factors, such as the organisation; and macro factors, such as regulation and national policies. Using ethnographic case studies enabled the researchers to investigate the issues in depth and develop a holistic understanding of them from a range of data collection methods.

The three case studies used a range of data collection methods, including participant observations, and semi-structured interviews with newly qualified nurses ($n=28$), healthcare assistants ($n=10$) and ward managers and matrons ($n=12$). A total of 33

Peer review

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KEY POINT

During the interviews and observations, the authors investigated how newly qualified nurses managed concerns about healthcare assistants' performance, and factors affecting how they organise, delegate and supervise care. Participant observation enabled the researchers to explore how newly qualified nurses learned to delegate in clinical practice. The researchers observed daily activities, rituals, interactions and ward cultures

newly qualified nurses were observed for a total of 230 hours. Each nurse was observed on two occasions by a researcher or qualified nurse for three to four hours. The newly qualified nurses were all in their first year post-registration, and the majority were undertaking a preceptorship programme. The hospital wards on which newly qualified nurses were observed included emergency assessment, older people, trauma, surgical, high dependency, and gastroenterology. Table 1 shows the data collected from each of the three hospital sites.

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The interviews and field notes were transcribed verbatim. Interview transcripts and observation notes were analysed using the thematic analysis framework employed by Guest et al (2012). The qualitative software package NVivo was used to manage and store the data. Data collection was carried out by the authors, primarily by the first author (CM). Data analysis workshops were held throughout the project to enable the researchers to develop a thematic coding framework to analyse the data.

Ethical approval was sought and gained in August 2011 from the NHS research authority, as well as research and development clearance from each of the three hospital sites and each researcher's university ethics committee. All of the participants received information about the study and provided informed written consent. Confidentiality was maintained throughout the study and interview transcripts and information were stored securely in locked cabinets.

Findings

From the thematic analysis of the participant observations and interviews, the authors identified five delegation styles, characterised by the approach to delegating used by the newly qualified nurse. An overview of each of these styles is provided in Box 1. Each delegation style has advantages and disadvantages, and different effects on patient care and safety, and working relationships.

BOX 1. Delegation styles used by newly qualified nurses

- » **The do-it-all nurse:** completes most of the work themselves
- » **The justifier:** over-explains reasons for decisions and is sometimes defensive
- » **The buddy:** wants to be everybody's friend and avoids assuming authority
- » **The role model:** hopes that healthcare assistants will copy their best practice but has no way of ensuring how this is done
- » **The inspector:** is acutely aware of their accountability and constantly checks the work of healthcare assistants

TABLE 1. Data collected from the three hospital sites

	Site A	Site B	Site C	Total
Newly qualified nurse observations	17 nurses 34 observations	6 nurses 12 observations	10 nurses 20 observations	33 nurses 66 observations
Nurse interviews	16	4	8	28
Healthcare assistant interviews	6	2	2	10
Ward manager and matron interviews	5	3	4	12

It is important to note that each nurse does not necessarily use only one of these delegation styles. Each nurse demonstrated a combination of these styles to manage situations in their daily clinical practice, varying which style they used based on experience, trial and error, and the social context.

The do-it-all nurse

The most common style of delegation identified in the thematic analysis was the do-it-all nurse. The findings indicated that many newly qualified nurses actively avoided delegation because of a lack of confidence. They also often felt that the healthcare assistants had more experience, and therefore did not want to tell them what to do. The researchers observed how nurses and healthcare assistants often worked in parallel with each other, with little interaction:

‘So I’ve [taken] on too many jobs myself and maybe that led to me not prioritising my time really’ (Site C/interview/nurse 2).

The do-it-all nurses often stayed beyond their shifts to complete paperwork. They reported feeling tired and overwhelmed, and that they sometimes were not able to complete important planned tasks during their shifts or that care-giving was delayed:

‘With my delegating I don’t think I’m very good, so I’m trying to do everything at the minute and then realising that you know, I’m not really delegating’ (Site A/interview/nurse 12).

Healthcare assistants reported that they felt newly qualified nurses did not trust them to do their jobs and that they felt undermined as a result:

‘When [nurses are] newly qualified they come out to the wards they’re fine they want to do it all... we know what we’re talking about, you have to prove yourself to a lot of the newly qualified nurses who have never worked as a healthcare assistant’ (Site C/interview/healthcare assistant 1).

The ward managers who were interviewed recognised that this approach was ineffective:

‘A newly qualified [nurse] would say “oh what do I do now?” you know... they feel they’re not powerful enough to delegate for some reason... all nursing is about delegation most of the time because you can’t do everything on your own you know, so I think we all [need to] work together, university and here, to teach them this’ (Site C/interview/ward manager 3).

The justifier

Another common delegation style to emerge from the data was the justifier. This describes newly qualified nurses who felt they needed to justify all their decisions and explain to the healthcare assistant exactly why they needed their help. This approach was linked to defensive practice, and the newly qualified nurses felt it was necessary to defend their authority and newly acquired senior position. The newly qualified nurses were uncomfortable doing this, and in the interviews they often linked needing to justify delegation to a lack of confidence or a concern that they might be perceived as lazy or not working hard enough:

‘I’m getting more confident with it but when I started I’ll be like “oh can you just get someone to change [the patient] because I’m in the middle of my medications and I don’t want to get behind”. That was how I delegated. But now I’m just like “can you just go and change that patient please”’ (Site A/interview/nurse 9).

‘I think more when you’re new that you, obviously, don’t want them to think that you’re a bit lazy and you’re not willing to work as a team and that you’re just happy to over-delegate. This sort of “You do this, this, this and this and I’ll just sit here and write this”’ (Site C/interview/nurse 3).

For newly qualified nurses who over-justified their decisions, a consequence was that their authority was undermined, and healthcare assistants also felt undermined

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KEY POINT

The role model style of delegation involved nurses attempting to role model behaviours to healthcare assistants to show them how to deliver optimum care. This might have seemed a productive approach, but it frequently stemmed from newly qualified nurses not being able or confident enough to verbalise their plans or desired standards of care. Instead, the nurses hoped that healthcare assistants would 'pick up' on the best models of care, but they often did not know if any learning had actually occurred

by being given information they already knew or understood:

'We're healthcare assistants we're not babies. We don't need people over us all the time. We can do our jobs' (Site C/interview/healthcare assistant 2).

The buddy

The buddy delegation style was characterised by newly qualified nurses who were concerned about being perceived as being bossy, so instead tried to be everybody's friend:

'I'm obviously quite young, quite inexperienced and again my nature is to be everybody's friend and to have that kind of friendship with my colleagues. Sometimes that's kind of worked against me because when I ask people to do things, sometimes, because of the relationship that I've built up with them as a friend, they don't always kind of, this sounds really awful, but respect [me]' (Site A/interview/nurse 7).

The outcome of this was that often healthcare assistants did not view these newly qualified nurses as being senior to them. The researchers observed healthcare assistants ignoring instructions from newly qualified nurses and taking longer breaks than agreed, resulting in wards being under-staffed. The newly qualified nurses frequently learned by trial and error and tried to change their approach. There was also evidence that newly qualified nurses wanted to avoid being viewed as being bossy because of the concerns raised by healthcare assistants about nurses who 'bossed them around', so it is possible that newly qualified nurses' views also stemmed in part from the attitudes of others and the prevailing culture. From the interviews, it was found that newly qualified nurses' desire to be everybody's friend was linked to a lack of confidence and a fear of assuming authority. The healthcare assistants were aware of this and often felt frustrated about what they perceived to be a lack of knowledge and experience among newly qualified nurses:

'They're supposed to be above me but I can't take orders off somebody who doesn't know what they're doing... I find I'm having to tell them what to do and it's frustrating for me because they're supposed to be my seniors' (Site A/interview/healthcare assistant 2).

As a consequence of the newly qualified nurses' lack of authority, some healthcare assistants worked largely unsupervised and the researchers also observed healthcare assistants making clinical decisions on their own that appeared to be beyond their role and responsibilities.

The role model

The role model style of delegation involved nurses attempting to role model behaviours to healthcare assistants to show them how to deliver optimum care. This might have seemed a productive approach, but it frequently stemmed from newly qualified nurses not being able or confident enough to verbalise their plans or desired standards of care. Instead, the nurses hoped that healthcare assistants would 'pick up' on the best models of care, but they often did not know if any learning had actually occurred:

'I think what I would do is, I'd maybe do the same job so they could hear me do it, so I would make an example, but without them knowing it' (Site B/interview/nurse 4).

The researchers observed that this role model approach resulted in the healthcare assistants lacking clarity about what the newly qualified nurse expects of them.

The inspector

The inspector delegation style involved newly qualified nurses repeatedly checking the work of the healthcare assistants. These nurses were aware of their accountability for care and were concerned that mistakes could be made or tasks not completed. Their method of delegation involved acting as a reviewer or an inspector:

'Well if I delegate them [tasks] to them [healthcare assistants]... and then 30 minutes after, I'll go back and see – I'll be

like “have you like kind of done that for me?”, and “can I ask for a report back that that’s actually been done?” Because I know on some occasions when I first started I [wasn’t] good at the delegation side, I’d do it a bit wrong then [things] weren’t getting done. So I’ve realised that I need to delegate correctly, to the correct level’ (Site A/interview/nurse 3).

The result of this approach was that, if delegated tasks had to be checked all the time, it negated the time-saving advantages of delegation and the healthcare assistants were left feeling they were not trusted by the newly qualified nurse. This is not to say that delegated tasks should not be monitored, but rather that monitoring needs to be done in a balanced and effective way. The following extract shows how some nurses were able to develop an approach that involved only double-checking abnormal observations:

‘Yeah, I mean as a staff nurse you’re ultimate, you know on our training into the trust we’re told we’re ultimately accountable for care assistants and those who work under us so anything they sign or anything they do, if they get it wrong it’s our PIN [the unique number issued to each nurse and midwife when they first join the NMC register], I think it’s part of the training we’re aware that you always check everything that everybody does, so like their observations, if they’re taking a patient’s observations you know, I wouldn’t go and re-take it after they’ve done it because that’s pointless – it’s two people doing the same job, but if it is a strange reading from what other readings are then I would re-take it’ (Site B/interview/nurse 2).

The research also found that learning to delegate was often ‘invisible’ since the newly qualified nurses learned this skill through making mistakes, by muddling through difficult and demanding situations, and informally from colleagues (Allan et al 2016). The findings also suggested that newly qualified nurses learn to assume authority during the time when they

transition from student to registered nurse, which places them in a challenging position when delegating tasks to healthcare assistants (Allan et al 2015).

Discussion

This study identified five styles of delegation used by newly qualified nurses when working with healthcare assistants. The authors have discussed the potential disadvantages of each style: the do-it-all nurse ends up being overworked, with important patient care and tasks not being completed, and healthcare assistants are excluded; the justifier over-explains, undermining their own authority and the healthcare assistants’ knowledge and expertise; the buddy does not maintain professional boundaries; the role model lacks direction; and the inspector wastes time and undermines the healthcare assistant by over-checking. However, each of these styles also contains elements of effective practice. The do-it-all nurse serves as a reminder that newly qualified nurses should share bedside care responsibilities with healthcare assistants; the justifier demonstrates the importance of explaining reasons for less obvious decisions; the buddy demonstrates the need to maintain positive, supportive professional relationships; the role model sets professional standards through their own performance; and the inspector demonstrates the importance of supervising delegated tasks. In each case, it is a matter of degree and of achieving a balanced approach to delegation.

The study showed that delegation is an underdeveloped skill among newly qualified nurses. This skill is difficult to assess because it relies on personality, communication style and mutual respect between the nurse and the healthcare assistant (Cipriano 2010). The study also indicated that healthcare assistants were often frustrated by blurred role boundaries and lack of direction and authority from newly qualified nurses. Munn et al (2013) suggested that a lack of clarity in healthcare assistant roles caused confusion during delegation of tasks, while a large-scale UK survey showed that many

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KEY POINT

The study suggests that newly qualified nurses need to be able to exercise personal authority to become competent nurses. The ability to be assertive when giving instructions, to constructively challenge colleagues, and to say 'no' in the face of competing time pressures and demands is essential to this authority. Assertiveness is contingent on an individual nurse's personality and communication style, and some nurses may find it easier to be assertive than others. Given its importance in nurse competence, teaching assertiveness skills, and providing safe spaces in which to practise those skills, would enhance nurses' development in delegating care competently and safely.

healthcare assistants felt unsupported in their roles (Bradley 2013).

The nurses' development of skills relating to the prioritisation, delegation and supervision of care is important. Documentation of care, mostly on computers, is a particularly time-consuming priority for qualified nurses in a highly accountable culture. Many nurses feel that this takes them away from the care of patients at the bedside (Johnson et al 2015). Consequently, they are increasingly turning to healthcare assistants to deliver care to patients (Johnson et al 2015). The pre-registration nursing curriculum only partially prepares nursing students for the demands of supervision, delegation and accountability. The newly qualified nurses in the study reported that they had limited opportunities to practise delegation and to develop the confidence and authority necessary to supervise and organise care during their pre-registration education. There is a need for increased focus on learning in these areas.

With the increasing significance of delegation for the nursing role, this study suggests that there is a need for delegation and supervision to be included in the nursing pre-registration curriculum and preceptorship programme. In addition, there should be greater clarity for nurses about what constitutes safe delegation and supervision, and how this can be achieved. It is important for nurses to improve their delegation skills (Curtis and Nicholl 2004) because 'one of the most complex nursing skills is that of delegation. It requires sophisticated clinical judgement and final accountability for patient care' (Weydt 2010). It has also been suggested that current pre-registration nurse education does not prepare nursing students to carry out this role (Hasson et al 2013). Although mentors in practice are expected to prepare nursing students to work with healthcare assistants, barriers to delegation have been reported by nursing students, such as nursing hierarchies and a fear of conflict (Hasson et al 2013). The authors suggest

that training and confidence-building may be required to help newly qualified nurses to improve their skills. Multiple, multimodal teaching strategies might need to be used to support this process (Josephsen 2013).

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Limitations

Observing how nurses learn to supervise and delegate care is challenging, because delegation is difficult to measure and occurs in the context of daily clinical practice. Although participant observation is resource intensive and time consuming, it was the only data collection method that would capture the complexities of supervision and delegation between nurses and healthcare assistants in hospital wards.

When carrying out participant observation, it has been suggested that participants may change the way they usually behave when they are not being observed. The researchers were aware of this and spent time developing rapport and trust between themselves and the participants. This included reassuring the nurses that they were not being assessed or judged on their clinical performance. The researchers also ensured that the observations did not distract from the delivery of care, and left the clinical area if requested by the nurse being observed. The nurses stated that they frequently forgot that they were being observed, because their focus was on service delivery and providing patient care.

Conclusion

The consequences of suboptimal or no delegation in the healthcare setting can have negative effects on patient safety. Therefore, newly qualified nurses require educational and organisational support to develop safe and effective delegation skills. It is important for nurses and managers to be aware of the different delegation styles that newly qualified nurses may adopt, the advantages and disadvantages of each approach, and the effects they may on patient care and safety, and working relationships within the multidisciplinary team.

IMPLICATIONS FOR PRACTICE

- » Nurses approach delegation in different ways because of different personalities, and levels of confidence. It is important for nurses and nurse managers to reflect on what effects the different styles have on patient care and safety, and working relationships in the multidisciplinary team.
- » Nurse academics and practice educators should consider how to update nursing curricula to include both theoretical and practical opportunities for nursing students to learn how to delegate and supervise care.
- » Nurses and nursing students will benefit from continued assertiveness training during pre-registration education and continuing professional development. This should include development of communication skills, self-awareness and emotional awareness.

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